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RURAL MANAGED CARE AND DISABILITY

Emerging Issues from Preliminary Interviews and Case Studies

Since the 1980s, rural access to health care information, resources and services has become increasingly problematic. The shift toward managed care complicates the picture. While some argue that managed care will devastate rural health services due to sparsely populated areas' high costs and low profit margins, others suggest that market forces will make the health care system more efficient and re-distribute resources now concentrated in urban areas toward rural areas.

Managed care is penetrating public programs such as Medicaid at an amazing rate (General Accounting Office, 1996). The RTC: Rural is working with the Research and Training Center on Managed Care at the National Rehabilitation Hospital (NRH) Center for Health and Disability Research (CHDR) to examine how Medicaid managed care programs can meet the diverse, on-going health care needs of rural people with disabilities. Interviews and focus groups with consumers and other stakeholders are identifying health care service issues resulting from rural managed care contracts.

The proliferation of managed care during the 1990s was striking. As recently as 1992, more than half of the U.S. workforce was covered by a traditional employer-provided indemnity plan.

By 1999, 85 percent of Americans with employer-based coverage were in managed care plans. As part of this powerful trend, states began to shift to Medicaid managed care programs. Slightly over half of all U.S. rural counties were covered by some type of Medicaid managed care in early 1997, and one in ten had a mandatory fully capitated program (Agency for Health Care Policy and Research, 1998). The complex and often emotional debate over the pros and cons of managed care as a health delivery system for people with disabilities and its effects in rural areas will be ongoing; however, health care issues of best practices and regulatory methods are immediate concerns.

Research Process

In addition to extensive literature reviews, RTC: Rural staff are conducting interviews and case studies to identify developing issues. We visited New Mexico, a rural state with a Medicaid managed care program that includes people with disabilities, to conduct interviews and focus groups. Participants included personnel from eight service-providing organizations, three departments of a Medicaid managed care organization, 12 advocates and consumers, and representatives of the Department of Health and the Health and

The Research & Training Center on Rural Rehabilitation Services conducts applied research designed to build upon the strengths of rural individuals and communities to solve the problems of daily life. This series of reports makes research results available as soon as is practical. Note that data presented are preliminary and must be interpreted with caution. The major limitations are reported. Please contact project staff to discuss issues presented.

Human Services Department. NRH-CHDR researchers conducted site visits in Texas and Delaware, which have also implemented Medicaid managed care for people with disabilities. We also reviewed Washington state's effort to include people with disabilities in Medicaid managed care. The following summarizes our observations.

Preliminary Findings: Issues for Rural Individuals with Disabilities

Access to General Practitioners and Specialists

The three New Mexico managed care companies which contract to provide Medicaid services require medical providers who have contracted to serve their large private-pay markets to also accept Medicaid patients. Consequently, the number of providers who accept Medicaid patients is **higher** under managed care than it was under fee-for-service. A public health nurse reported that a small, isolated New Mexico community has two physicians in the area. Under the new Medicaid managed care program, both physicians are available to Medicaid enrollees. They had not accepted Medicaid patients under the old fee-for-service system.

In a Santa Fe focus group, RTC: Rural staff questioned Medicaid participants with disabilities about the effects of managed care on general practitioner availability. New Mexico Medicaid-only recipients are in the managed care program, but dual-eligible individuals (with both Medicare and Medicaid) are enrolled in fee-for-service systems. Persons with disabilities in managed care as well as persons with disabilities in fee-for-service programs were represented at the focus group in Santa Fe. Three of the four individuals in fee-for-service who attended the focus group were served by physicians in public clinics. They reported high staff turnover (being cared for by a new doctor each year) and long waits for appointments. Two people in managed care and one person in fee-for-service saw private physicians. The people with disabilities in managed care were happier with their choice of physicians than the

Research Goals

1. **Evaluate** state-sponsored health care reform **initiatives** in managed care for people with disabilities.
2. **Identify** health care service **issues** resulting from rural managed care through focus groups with consumers and other stakeholders.
3. **Publish** a best practices **monograph** using case studies to describe factors unique to individuals with disabilities who live in rural areas.

people with fee-for-service Medicaid. The individuals in managed care were happier with their physicians, stayed with the same physician longer, and experienced fewer delays in getting appointments. The person in the fee-for-service program who was as happy as the people in managed care had a long-term patient-private physician relationship and her communication and **navigational skills** (described below) were very strong.

Case Management and Navigation of the System

"Navigation of the system" refers to the tasks of getting services: learning about available products and services; scheduling appointments; arranging medical-related transportation; and obtaining needed products and services.

The assignment of case managers to health plan enrollees could be one strategy for improving system navigation, if case loads were not too large. A case manager is assigned upon Medicaid enrollment in Texas, if the risk assessment (probability of medical need) is high. In New Mexico, a primary care physician, a specialist, or the patient himself can request a case manager. A case manager may also be assigned if medical management data indicate someone is using a lot of services. Medical management data include encounter data, prescriptions used, emergency room use and other service utilization.

Providers in Las Cruces, New Mexico, reported social workers with case loads of 400 clients spread over a two-county area. In this instance, a case manager would have more difficulty assisting enrollees. A home health agency director in very isolated, very rural Santa Rosa, New Mexico, suggested that there are few caseworkers because salaries are low. He had considered acquiring caseworker certification, but the salary wasn't worth the extra effort and time required for certification.

New Mexico also eases navigation with Medical Off Site Application Assistance (MOSAA). Twelve hundred sites have been selected to train providers to expedite the enrollment process. One very pleased rural public health nurse who had received MOSAA training said that, upon confirming a woman's pregnancy, she can immediately sign the patient up for Medicaid. The patient need not navigate the Income Assistance (welfare) system. This nurse had seen women refuse prenatal services rather than sacrifice their privacy by going to the welfare office.

The New Mexico Medicaid program sought proxy or advocacy group assistance for system navigation and enrollment. In the program's developmental phase, the state contracted with advocacy groups such as The ARC (a national organization on mental retardation), and the state Multiple Sclerosis Support Group, to represent their constituents' needs. The Arc of New Mexico is based in Albuquerque, and providers have noted that it could be very hard for rural consumers to connect with urban organizations. Also, few advocacy groups are present in rural areas.

Risk Adjustment

Managed care companies may adjust contracts for enrollees with high-cost medical needs (due to health status or to geographical location). This is called **risk adjustment**.

Risk adjustment was not in place when Washington state implemented managed care for Medicaid recipients. State officials believed that enrollment in managed care would greatly improve access to services for individuals with

disabilities. However, increased access meant increased use of services and higher costs to health plans. By the end of 1997, 8,300 individuals with disabilities in rural eastern Washington had been enrolled in capitated managed care plans. The state also operated a Primary Care Case Management pilot program in Clark County for about 1,500 enrollees. In January 1998, all of these individuals were disenrolled from managed care and returned to the fee-for-service system. Having experienced utilization and costs as high as 35 percent above the reimbursement rate, some health plans had become reluctant to participate in the program. The Medicaid program, constrained by a limited budget and a legislative mandate to operate the managed care program for enrollees at a discount (99 percent of fee-for-service), refused to increase reimbursement rates for enrollees with disabilities. The state also canceled plans for mandatory managed care for its western Medicaid recipients with disabilities, scheduled to begin in 1998. (Regenstein, & Anthony, 1998)

New Mexico also did not establish risk adjustment for rural Medicaid recipients with disabilities. The state establishes managed care reimbursement rates by cohort type (age, gender, AFDC, TANF, etc.). Geography and health status are not considered. The CEO of a managed care organization stated that services to rural individuals with disabilities were not an issue; their special needs had probably already forced most rural New Mexicans with disabilities to relocate to Albuquerque. This managed care official assigned no value to rural quality of life, or support of family and friends.

Availability and cost of durable medical equipment (DME) are also different in rural service areas. A Santa Rosa DME provider refused to contract as a managed care provider and therefore was unable to provide equipment and services to Medicaid recipients. His refusal stemmed from Medicaid's practice of paying the same prices for equipment in rural areas as it pays in the larger cities. There was no adjustment for the fact that providing the same services in a rural area is more

expensive. Santa Rosa Medicaid recipients find it harder under managed care to get equipment from providers in the larger cities.

Program Development: Awarding Contracts for State Sponsored Medicaid Programs

New Mexico Medicaid officials described a mechanism which could be used to respond to the Medicaid managed care issues we have identified. New Mexico issued a very specific Request for Proposals (RFP) to managed care companies which were bidding for the state contract to serve the Medicaid population. The RFP required that the bids address specific issues. For example, rather than require that the bid include "evaluation of member services", the RFP stated that the bid would include a monthly evaluation of phone calls from enrollees and service providers, including the number of successful calls, the nature of

each call, the average length of the average call, and the abandonment rate. In other words, the managed care company had to complete program development before its bid was accepted. This required the company to submit realistic bids that reflect the cost of services identified as important.

Next Steps

State sponsored Medicaid managed care programs vary widely in their implementation of policies and the time elapsed since their initiation. A series of **case studies** would allow us to identify issues and compare the rural and urban perspectives on health care services resulting from managed care contracts.

Where issues have been identified, follow-up interviews could determine best policy responses. **Best policy and practices** could then be described in **monographs** and **fact sheets** for distribution to key stakeholders and those who make policy for rural areas.

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